Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

RGV HEALTHCARE SYSTEM
BOX 6582
MCALLEN TX 78502

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number
M4-10-1332-01

MFDR Date Received
OCTOBER 30, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "$0.00 paid"

Amount in Dispute: $113.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "An in-depth review was performed of the disputed charges and supporting documentation, the Office contacted the requestor to obtain additional information concerning the charges. In the course of the conversation with RGV Healthcare Systems and the injured workers treating physician's office it was determined that the charges being billed are for services that Gary Molina performed consulting with a peer physician on behalf of the treating doctor concerning the injured workers treatment plan. It was also determined that Mr. Molina is not the injured workers treating physician and therefore not eligible for reimbursement billing CPT code 99361…The documentation that was submitted to the Office by the peer physician indicates that the conversation concerning the injured worker's treatment plan was held with Mr. Molina which Dr. Tonn references him as Dr. Molina (Exhibit I), it is also determined that Mr. Molina is not a physician nor the injured worker's treatment physician. Therefore the Office has determined that Mr. Molina with RGV Healthcare Services isn't eligible for reimbursement for the CPT code being billed."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 4, 2009	CPT Code 99361-W1 Medical Conference with Team	$113.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets out medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 128-Please re-submit with appropriate CPT-4 code.
- 16-Not all info needed for adjudication was supplied.
- 150-Payment adjusted/unsupported service level.
- W1-Case management services.
- W4-No additional payment allowed after review.

Issues

Is the requestor entitled to reimbursement?

Findings

The respondent denied reimbursement for the case management services, CPT code 99361, based upon the services were not documented with reason codes "128," "16," and "150"

28 Texas Administrative Code §134.204(e)(4) states "Case management services require the treating doctor to submit documentation that identifies any HCP that contributes to the case management activity. Case management services shall be billed and reimbursed as follows:

(A) CPT Code 99361.

(i) Reimbursement to the treating doctor shall be $113. Modifier 'W1' shall be added."

Review of the submitted documentation finds that the requestor did not submit a report to support the case management service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	03/28/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.